REHABILITATIVE SERVICES: REIMBURSEMENT FOR DRUG MEDI-CAL PROGRAM

Section 1: Reimbursement for Substance Use Disorder Treatment Services

This segment of the State Plan describes the reimbursement methodology for Substance Use Disorder Treatment Services covered under the rehabilitation benefit and rendered by qualified providers as described in Supplement 3 to Attachment 3.1 A to this State Plan. Qualified providers are DMC certified providers that must be licensed, registered, enrolled, and/or approved in accordance with all applicable state laws and regulations; abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services (DHCS); and sign a provider agreement with a county or DHCS. During the period beginning October 1, 2020 and ending September 30, 2025, Medication for Addiction Treatment for Opioid Use Disorder (MAT for OUD) Services are exclusively covered and reimbursed under the 1905(a)(29) benefit.

A. Definitions

"Narcotic Treatment Program Services" means Narcotic Treatment Program (NTP) Daily Dosing Services and Individual Counseling, Group Counseling and Peer Support Services as those services are defined in Section 13.d.5 of Supplement 3 to Attachment 3.1-A of this State Plan.

"Narcotic Treatment Program Daily Dosing Services" means NTP Core Services, NTP Laboratory Work, MAT for Alcohol Use Disorder and Other Non-Opioid Use Disorders (AUD) Medications, and MAT for OUD Medications.

"NTP Core Services" means Assessment, Medical Psychotherapy, Medication Services, Patient Education, and Substance Use Disorder (SUD) Crisis Intervention Services as those services are defined in Section 13.d.5 of Supplement 3 to Attachment 3.1-A of this State Plan.

"NTP Laboratory Work" means Tuberculin and Syphilis tests, monthly drug screening, and monthly pregnancy tests of female methadone patients.

"Medication for Addiction Treatment for Opioid Use Disorder (MAT for OUD) Medications" means all forms of drugs approved to treat opioid use disorder under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 355) and all biological products licensed to treat opioid use disorder under Section 351 of the Public Health Services Act (42 U.S.C. § 262).

"Outpatient Services" means Assessment, Group Counseling, Individual Counseling, Medication Services, Patient Education, MAT for OUD, and SUD Crisis Intervention Services when provided in an Outpatient Treatment Services Level of Care or Intensive Outpatient Treatment Services Level of Care; and Peer Support Services, when provided in any Substance Use Disorder Treatment Level of Care as those services and levels of care are defined in Section 13.d.5 in Supplement 3 to Attachment 3.1-A of this State

Plan.

"Eligible Provider" means a public or private provider enrolled in the Medi-Cal program and certified to provide one or more Expanded Substance Use Disorder Services" as those services are defined in Section 13.d.6 in Supplement 3 to Attachment 3.1-A of this State Plan.

"Home Health Agency Market Basket Index" means the IHS Global Inc. CMS Market Basket Index Levels for Home Health Agencies.

"Licensed Practitioner of the Healing Arts (LPHA)" means Licensed Clinical Social Worker (LCSW), Waivered/Registered LCSW, Licensed Professional Clinical Counselor (LPCC), Waivered/Registered LPCC, Marriage and Family Therapist (MFT), and Waivered/Registered MFT as those terms are defined in Supplement 3 to Attachment 3.1-A.

"Provider Type" means Physician, Psychologist, Waivered Psychologist, Registered Nurse (RN), Physician Assistant (PA), Nurse Practitioner (NP), Pharmacist, Registered/Certified Alcohol and Drug Counselor, and Peer Support Specialists as those terms are defined in Supplement 3 to Attachment 3.1-A of this State Plan; and Licensed Practitioner of the Healing Arts.

"Substance Use Disorder Treatment Services" means Outpatient Services, Twenty-Four Hour Services, and Narcotic Treatment Program Services.

"Twenty-Four Hour Services" means Perinatal Residential Substance Use Disorder Treatment as defined in Section 13.d.6 in Supplement 3 to Attachment 3.1-A of this State Plan.

B. Outpatient Services Reimbursement Methodology

1. The State reimburses all eligible providers of Outpatient Services on a fee for service basis pursuant to a fee schedule established by the State. Eligible providers claim reimbursement for Outpatient Services using appropriate Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes. The fee schedule contains a rate for each county where the Eligible provider is located and combination of Provider Type and CPT®/HCPCS code.
2. Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers. The fee schedule that is effective July 1, 2023, and annually thereafter, is posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.
3. The State will annually increase the county specific per-unit rates for HCPCS and CPT Codes effective July 1, 2023 by the percentage change in the four quarter average Home Health Agency Market Basket Index.

C. Twenty-Four Hour Services Reimbursement Methodology

1. The State reimburses all eligible providers of Twenty-Four Hour Services on a fee for service basis pursuant to a fee schedule established by the State. Twenty-Four Hour Services are reimbursed a per diem rate. The fee schedule contains a rate for each county where the provider is located and each Twenty-Four Hour Service.
2. Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers. The fee schedule for Twenty-Four Services that is effective July 1, 2023, and annually thereafter, is posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.
3. The State will annually increase the county specific per-unit rates for 24-hour services effective July 1, 2023, by the percentage change in the four quarter average Home Health Agency Market Basket Index.

D. Narcotic Treatment Program Reimbursement Methodology

1. The State reimburses all eligible providers of Narcotic Treatment Program Services on a fee for service basis pursuant to a fee schedule established by the State. Narcotic Treatment Program Daily Dosing Services are reimbursed a per dose rate. An eligible provider must administer a MAT for OUD Medication or MAT for AUD Medication to be reimbursed for Narcotic Treatment Program Daily Dosing Services. The fee schedule contains a per dose rate for each county where the eligible provider is located. The per dose rate does not include the cost of room and board. Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers. The State will monitor the actual provision of Narcotic Treatment Program Daily Dosing Services reimbursed through this per dose rate.
2. The State reimburses all eligible providers for Group Counseling, Individual Counseling, and Peer Support Services provided in a Narcotic Treatment Program pursuant to the fee schedule established in Section B of this segment of the State Plan.
3. Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers The fee schedule for Narcotic Treatment Program Daily Dosing Services that is effective July 1, 2023, and annually thereafter, is posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.
4. The State will annually increase the county specific daily rates for Narcotic Treatment Program Daily Dosing Services effective July 1, 2023 by the percentage change in the four quarter average Home Health Agency Market Basket Index.

E. Community-Based Mobile Crisis Intervention Services Reimbursement Methodology

1. Community-Based Mobile Crisis Intervention Encounters
    a. The State establishes a county-based bundled rate for each encounter. Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers The county-based bundled rates effective July 1, 2023, and annually thereafter, are posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.
    b. The State reimburses all eligible providers the county-based bundled rate based upon the county where the provider is located.
    c. The county-based bundled rate is reimbursed for the following service components as those components are defined in Attachment 3.1-A of this State Plan:
        - Assessment
        - Mobile crisis response
        - Crisis planning
        - Referral to ongoing supports
        - Follow up check ins
    d. A provider must render at least one of the following service components during an encounter to be reimbursed the bundled rate:
        - Assessment
        - Mobile crisis response
        - Crisis planning
        - Referral to ongoing supports
    a. The state will annually increase the county-based bundled rates effective July 1, 2023 by the percentage change in the four quarter average Home Health Agency Market Basket Index.
2. Facilitation of a warm handoff
    a. The State will reimburse providers for facilitation of a warm handoff, as that service component is defined in Attachment 3.1-A of this State Plan, pursuant to a fee schedule established by the State. The fee schedule will include a rate for each county and the following aspects of the service component:
        - Providing and/or arranging for a beneficiary's transportation to an alternative setting to receive urgent treatment. The State will reimburse providers the standard mileage rate per mile for use of an automobile for medical care as established by the Internal Revenue Service.
        - Staff time spent providing and/or arranging for transportation to an alternative setting to receive urgent treatment. The rates for this aspect of facilitation of a warm handoff effective July 1, 2023.
3. The State will annually increase the fee schedules described in paragraphs 1 and 2 by the percentage change in the four quarter average Home Health Agency Market Basket Index.

Section 2: Reimbursement for Expanded Substance Use Disorder Treatment Levels of Care

This segment of the State Plan describes the reimbursement methodology for Expanded Substance Use Disorder Treatment Services covered under the rehabilitation benefit and rendered by qualified providers as described in Supplement 3 to Attachment 3.1 A to this State Plan. Qualified providers are DMC certified providers that must be licensed, registered, enrolled, and/or approved in accordance with all applicable state laws and regulations; abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services; and sign a provider agreement with a county. During the period beginning October 1, 2020 and ending September 30, 2025, MAT for OUD services are exclusively covered and reimbursed under the 1905(a)(29) benefit.

A. Definitions

“Narcotic Treatment Program Services” means Narcotic Treatment Program Daily Dosing Services and Care Coordination, Individual Counseling, Group Counseling, Peer Support Services, and Recovery Services as those services are defined in Section 13.d.6 of Supplement 3 to Attachment 3.1-A of this State Plan.

“Narcotic Treatment Program Daily Dosing Services” means NTP Core Services, NTP Laboratory Work, MAT for AUD Medications, and MAT for OUD Medications.

“NTP Core Services” means Assessment, Family Therapy, Medical Psychotherapy, Medication Services, Patient Education, and SUD Crisis Intervention Services as those services are defined in Section 13.d.6 of Supplement 3 to Attachment 3.1-A of this State Plan.

“NTP Laboratory Work” means Tuberculin and Syphilis tests, monthly drug screening, and monthly pregnancy tests of female methadone patients.

“Medication for Additional Treatment for Opioid Use Disorder (MAT for OUD) Medications” means all forms of drugs approved to treat opioid use disorder under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 355) and all biological products licensed to treat opioid use disorder under Section 351 of the Public Health Services Act (42 U.S.C. § 262).

“Medication for Addiction Treatment for Alcohol Use Disorder and Other Non-Opioid Use Disorders (MAT for AUD) Medications"

“Day Services” means Level 1 – Withdrawal Management (WM), Level 2 – WM, and Partial Hospitalization as those terms are defined in Section 13.d.6 in Supplement 3 to Attachment 3.1-A of this State Plan.

“Outpatient Services” means Assessment, Care Coordination, Family Therapy, Group

Counseling, Individual Counseling, Medication Services, Patient Education, and SUD Crisis Intervention Services when provided in an Outpatient Treatment Services Level of Care, Intensive Outpatient Treatment Services Level of Care, or Partial Hospitalization Level of Care; and Peer Support Services, Recovery Services, MAT for AUD, MAT for AUD Medication, MAT for OUD, and MAT for OUD Medication provided in any Expanded Substance Use Disorder Level of Care as those services and levels of care are defined in Section 13.d.6 in Supplement 3 to Attachment 3.1-A of this State Plan.

"Eligible Provider" means a public or private provider enrolled in the Medi-Cal program and certified to provide one or more Expanded Substance Use Disorder Services" as those services are defined in Section 13.d.6 in Supplement 3 to Attachment 3.1-A of this State Plan.

"Home Health Agency Market Basket Index" means the IHS Global Inc. CMS Market Basket Index Levels for Home Health Agencies.

"Licensed Practitioner of the Healing Arts (LPHA)" means Licensed Clinical Social Worker (LCSW), Waivered/Registered LCSW, Licensed Professional Clinical Counselor (LPCC), Waivered/Registered LPCC, Marriage and Family Therapist (MFT), and Waivered/Registered MFT as those terms are defined in Supplement 3 to Attachment 3.1-A.

"Provider Type" means Physician, Psychologist, Waivered Psychologist, Registered Nurse (RN), Licensed Vocational Nurse (LVN), Psychiatric Technician (PT), Mental Health Rehabilitative Specialist (MHRS), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Specialist (CNS), Pharmacist, Occupational Therapist (OT), Peer Support Specialists, and Other Qualified Provider as those terms are defined in Supplement 3 to Attachment 3.1-A of this State Plan; and Licensed Practitioner of the Healing Arts.

"Expanded Substance Use Disorder Treatment Services" means Outpatient Services, Twenty-Four Hour Services, NTP Services, and Withdrawal Management Services.

"Twenty-Four Hour Services" means Level 3.1 – Clinically Managed Low-Intensity Residential Services, Level 3.2 – WM, Level 3.3. – Clinically Managed Population-Specific High Intensity Residential Services, and Level 3.5 – Clinically Managed High Intensity Residential Services as those services are defined in Section 13.d.6 in Supplement 3 to Attachment 3.1-A of this State Plan.

"Regional County" means Humboldt County, Lake County, Lassen County, Mendocino County, Modoc County, Shasta County, Siskiyou County, and Solano County.

"Non-Regional County" means all counties in California except for Regional Counties.

B. Reimbursement Methodology – Non-Regional Counties

This segment of the State Plan describes the reimbursement methodology for providers

located in Non-Regional Counties

1. Outpatient Services Reimbursement Methodology

   a. The State reimburses all eligible providers of Outpatient Services in Non-Regional Counties on a fee for service basis pursuant to a fee schedule established by the State. Eligible providers claim reimbursement for Outpatient Services using appropriate Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes. The fee schedule contains a rate for each county where the eligible provider is located and combination of Provider Type and CPT®/HCPCS code. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers.
   b. The fee schedule that is effective July 1, 2023, and annually thereafter, is posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.
   c. The State will annually increase the per-unit rates for HCPCS and CPT Codes effective July 1, 2023 by the percentage change in the four quarter average Home Health Agency Market Basket Index. The updated rates will be posted to the webpage linked above annually.

2. Day Services Reimbursement Methodology

   a. The State reimburses all eligible providers of Day Services in Non-Regional Counties on a fee for service basis pursuant to a fee schedule established by the State. Level 1 – WM and Level 2 – WM are reimbursed an hourly rate. Partial Hospitalization is reimbursed a daily rate. The fee schedule contains a rate for each county where the provider is located and each Day Service. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers.
   b. The fee schedule for Day Services that is effective July 1, 2023, and annually thereafter, is posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.
   c. The State will annually increase the day service rates effective July 1, 2023 by the percentage change in the four quarter average Home Health Agency Market Basket Index. The updated rates will be posted to the webpage linked above annually.

3. Twenty-Four Hour Services Reimbursement Methodology

   a. The State reimburses all eligible providers of Twenty-Four Hour Services in Non-Regional Counties on a fee for service basis pursuant to a fee schedule established by the State. Twenty-Four Hour Services are reimbursed a per diem rate for all service components described in Section 13.d.6 in Supplement 3 to Attachment 3.1-A of this State Plan, except for Care Coordination, Recovery Support Services, Peer Support Specialist Services, MAT for OUD, and MAT for AUD. The fee schedule contains a rate for each county where the provider is located and each Twenty-Four Hour Service. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers.

b. The fee schedule for Twenty-Four Hour Services that is effective July 1, 2023, and annually thereafter, is posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.
c. The State will annually increase the per-unit rates for 24-hour services effective July 1, 2023 by the percentage change in the four quarter average Home Health Agency Market Basket Index.
d. Care Coordination, Recovery Support Services, Peer Support Specialist Services, MAT for OUD, and MAT for AUD services provided by eligible providers of Twenty-Four Hour Services are reimbursed pursuant to the methodology described in Section B.1 on page 41c.

4. Narcotic Treatment Program Reimbursement Methodology

a. The State reimburses all eligible providers of Narcotic Treatment Program Services on a fee for service basis pursuant to a fee schedule established by the State. Narcotic Treatment Program Daily Dosing Services are reimbursed a per dose rate. An eligible provider must administer MAT for OUD Medication or MAT for AUD Medication to be reimbursed for Narcotic Treatment Program Daily Dosing Services. The fee schedule contains a per dose rate for each County where the eligible provider is located. The per dose rate does not include the cost of room and board. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. The State will monitor the actual provision of Narcotic Treatment Program Daily Dosing Services reimbursed through this per dose rate.
b. The State reimburses all eligible providers for Care Coordination, Individual Counseling, Group Counseling, Peer Support Services, and Recovery Services provided in a Narcotic Treatment Program pursuant to the fee schedule established in Section 1, B1-3, “Outpatient Services Reimbursement Methodology,” on page 41c of this State Plan.
c. The fee schedule for Narcotic Treatment Program Daily Dosing Services that is effective July 1, 2023, and annually thereafter, is posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.
d. The State will annually increase the daily rates for Narcotic Treatment Program Daily Dosing Services effective July 1, 2023 by the percentage change in the four quarter average Home Health Agency Market Basket Index. The fee schedule for the Narcotic Treatment Program Daily Dosing Service is a bundled rate.
    i. Any Narcotic Treatment Program provider delivery Narcotic Treatment Program Daily Dosing Services will be paid through the bundle and cannot bill separately.
    ii. Any provider delivering services outside of the Narcotic Treatment Program Daily Dosing Services may bill for those separate services in accordance with this state plan.
    iii. The State will periodically monitor the actual provision of services paid under the Narcotic Treatment Program Daily Dosing Services bundled rate

to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the bundle.

5. Community-Based Mobile Crisis Intervention Services Reimbursement Methodology

a. Community-Based Mobile Crisis Intervention Encounters

i The State reimburses all eligible providers for Community-Based Mobile Crisis Intervention Encounters a county-based bundled rate for each encounter. The county-based bundled rates effective July 1, 2023, and annually thereafter, are posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.

ii The State reimburses all eligible providers, both governmental and private providers, the county-based bundled rate based upon the county where the provider is located.

iii The county-based bundled rate is reimbursed for the following service components as those components are defined in Attachment 3.1-A of this State Plan:
- Assessment
- Mobile crisis response
- Crisis planning
- Referral to ongoing supports
- Follow up check ins

iv A provider must render at least one of the following service components during an encounter to be reimbursed the bundled rate:
- Assessment
- Mobile crisis response
- Crisis planning
- Referral to ongoing supports

v Any provider delivering services through a bundle will be paid through that bundled payment rate and cannot bill separately. Providers delivering separate services outside of the bundle may bill for those separate services in accordance with the State's Medicaid billing procedures.

vi The state will annually increase the county-based bundled rates effective July 1, 2023 by the percentage change in the four quarter average Home Health Agency Market Basket Index.

vii The state will periodically monitor the actual provision of services paid under the county bundled rate to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the bundle.

b. Facilitation of a warm handoff

i. The State will reimburse all eligible providers for facilitation of a warm handoff, as that service component is defined in Attachment 3.1-A of this State Plan, pursuant to a fee schedule established by the State. The fee schedule will include a rate for each county and the following aspects of the service component:
   - Providing and/or arranging for a beneficiary's transportation to an alternative setting to receive urgent treatment. The State will reimburse providers the standard mileage rate per mile for use of an automobile for medical care as established by the Internal Revenue Service.
   - Staff time spent providing and/or arranging for transportation to an alternative setting to receive urgent treatment. The rates for this aspect of facilitation of a warm handoff effective July 1, 2023, and annually thereafter, are posted to the following webpage: https://www.dhcs.ca.gov/services/MH/Pages/medi-cal-behavioral-health-fee-schedules.aspx.

ii. The State will annually increase the fee schedules described in paragraphs 1 and 2 by the percentage change in the four quarter average Home Health Agency Market Basket Index.

C. Reimbursement Methodology for Regional Counties

1. The reimbursement methodology for all eligible providers of Outpatient Services, Day Services, and Twenty-Four Hour Services in Regional Counties is equal to the prevailing charges for the same or similar services in the county where the provider is located. Care Coordination, Recovery Support Services, Peer Support Specialist Services, MAT for OUD, and MAT for AUD services provided by eligible providers of Twenty-Four Hour Services are reimbursed as Outpatient Services separate from the Twenty-Four Hour Service. If prevailing charges are not available, the State will use the best available alternative data, subject to CMS review, that would serve as a reasonable proxy, including the use of trended historical data.
2. The State reimburses all eligible providers of Narcotic Treatment Program Services pursuant to Section B.4 above.
3. The State reimburses all eligible providers of Community-Based Mobile Crisis Intervention Services pursuant to Section B.5 above.

D. Regional Counties

Humboldt
Lassen
Mendocino
Modoc
Shasta
Siskiyou
Solano

E. Non-Regional Counties

Alameda	Napa	San Joaquin
Contra Costa	Nevada	San Luis Obispo
El Dorado	Orange	San Mateo
Fresno	Placer	Santa Barbara

Imperial
Kern
Los Angeles
Marin
Merced
Monterey
Riverside
Sacramento
San Benito
San Bernardino
San Diego
San Francisco
Santa Clara
Santa Cruz
Stanislaus
Tulare
Yolo

"Intensive Outpatient Treatment Level of Care" has the same meaning as defined in section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State Plan.

"Legal Entity" means each county alcohol and drug department or agency and each of the corporations, sole proprietors, partnerships, agencies, or individual practitioners providing Expanded Substance Use Disorder Treatment Services under contract with the county alcohol and drug department or agency or with DHCS.

"Medication for Addiction Treatment for Alcohol Use Disorder and Other Non-Opioid Use Disorders (MAT for AUD)" includes services to treat alcohol use disorder (AUD) and other non-opioid substance use disorders (SUD) involving FDA-approved medications to treat AUD and non-opioid SUDs. MAT for AUD does not include the FDA approved medication.

"Medication for Addiction Treatment for Alcohol Use Disorder and Other Non-Opioid Use Disorders (MAT for AUD) Medications" include all FDA approved medications to treat alcohol use disorders and other non-opioid use disorders.

"Medication for Addiction Treatment for Opioid Use Disorders (MAT for OUD)" includes services to treat Opioid Use Disorder (OUD) involving FDA-approved medications to treat OUD. MAT for AUD does not include the FDA approved medication.

"Medication for Addiction Treatment for Opioid Use Disorder (MAT for OUD) Medications" include all forms of drugs approved to treat opioid use disorder under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed to treat opioid use disorder under section 351 of the Public Health Services Act (42 U.S.C. 262).

"Community-Based Mobile Crisis Intervention Service" is a Rehabilitative Substance Use Disorder Service as defined in Supplement 3 to Attachment 3.1-A of this State plan.

"Narcotic Treatment Program (NTP) Level of Care" is a subset of Expanded Substance Use Disorder Levels of Care and includes Daily Dosing services as described in Section C below and Individual and Group Counseling services as described under section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State plan.

"Non-Narcotic Treatment Program (non-NTP) Levels of Care" is a subset of Expanded Substance Use Disorder Levels of Care and includes Outpatient Treatment Services Level of Care, Intensive Outpatient Treatment Level of Care, Partial Hospitalization Level of Care, Residential Treatment Level of Care, and Withdrawal Management Level of Care as described under section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State plan.

"Non-Regional Counties" means those counties listed in Section H of this segment to this State plan.

"Outpatient Treatment Services Level of Care" has the same meaning as defined in section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State Plan.

"Partial Hospitalization Level of Care" has the same meaning as defined in Section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State Plan.

"Provider of Services" means any private or public agency that provides Expanded Substance Use Disorder Treatment Services and is certified by the State as meeting applicable standards for participation in the DMC Program, as defined in the Drug Medi-Cal Certification Standards for Substance Use Disorder Clinics.

"Published Charges" are usual and customary charges prevalent in the alcohol and drug treatment services sector that are used to bill the general public, insurers, and other non-Title XIX payers. (42 CFR §§ 447.271 and 405.503(a)).

"Regional Counties" means those counties listed in Section G of this segment to this State plan.

"Residential Treatment Level of Care" has the same meaning as defined in Section 13.d of Supplement 3 to attachment 3.1-A to this State Plan.

"Statewide Maximum Allowance" (SMA) is an interim rate established for each type of non-NTP Level of Care and Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care per unit.

"Withdrawal Management Level of Care" has the same meaning as defined in section 13.d.6 of Supplement 3 to Attachment 3.1-A to this State plan.

B. **ALLOWABLE EXPANDED SUBSTANCE USE DISORDER TREATMENT LEVELS OF CARE AND UNITS OF SERVICE – REGIONAL AND NON-REGIONAL COUNTIES**

1. Allowable Expanded Substance Use Disorder Levels of Care and units of service are as follows:

Non-NTP Levels of Care	Unit of Service (UOS)
Intensive Treatment Outpatient Services	15-Minutes
Outpatient Treatment Services (also known as Outpatient Drug Free or ODF)	15-Minutes
Residential Treatment	24-hour structured environment per day (excluding room and board)

Partial Hospitalizatio	Daily
Withdrawal Management ASAM Levels 1 and 2	Daily
Withdrawal Management ASAM Level 3.2, 3.7, and 4.0	24-hour structured environment per day (excluding room and board)

Narcotic Treatment Program Level of Care (consist of two components):

a) Daily Dosing	Daily bundled service which includes the following components: A. Core: Assessment, medication services, treatment planning, physical evaluation, drug screening, and supervision. B. Laboratory Work: Tuberculin and syphilis tests, monthly drug screening, and monthly pregnancy tests of female methadone patients. C. Dosing: Ingredients and labor cost for Medication for Addiction Treatment (MAT) for Alcohol Use Disorder (AUD) and MAT for Opioid Use Disorder (OUD).
b) Counseling Individual and/or Group	10-Minutes

2. The following Expanded Substance Use Disorder Treatment Services are reimbursed separately from the Level of Care payment when provided in a Non-NTP Level of Care or outside of any Expanded Substance Use Disorder Treatment Level of Care:

Services and Drugs	Units
Recovery Service	15 Minutes
Peer Support Service	15 Minutes
Care Coordination Service	15 Minutes
MAT for AUD	15 Minutes
MAT for AUD Medication	Dose
MAT for OUD	15 Minutes
MAT for OUD Medication	Dose
Community-Based Mobile Crisis Intervention Services	Encounter

3. The following Expanded Substance Use Disorder Treatment Services are

reimbursed separately from the Level of Care payment when provided in a NTP Level of Care:

Service	Units
Recovery Service	15 Minutes
Peer Support Service	15 Minutes
Care Coordination Service	15 Minutes
Community-Based Mobile Crisis Intervention Services	Encounter

C. **REIMBURSEMENT METHODOLOGY – NON-REGIONAL COUNTIES**

1. The reimbursement methodology for Non-NTP Levels of Care and Expanded Substance Use Disorder Treatment Services Provided Outside a Level of Care rendered by county operated providers is equal to the provider's allowable cost of providing the level of care or service pursuant to Section D below.

2. The reimbursement methodology for Non-NTP Levels of Care and Expanded Substance Use Disorder Treatment Services Provided Outside a Level of Care rendered by non-County operated providers is equal to the lowest of:
   a. The provider's usual and customary charge to the general public for the same or similar level of care, or
   b. The provider's allowable cost of providing the level of care or service.

3. The reimbursement methodology for NTP levels of care for non-county operated NTP providers is the lowest of:

   a. The provider's usual and customary charge to the general public for the same or similar level of care, or
   b. The uniform statewide daily reimbursement rate (USDR) established in Section D.1.b below.

4. The reimbursement methodology for NTP Levels of Care for county-operated providers is the lowest of:

   a. The provider's usual and customary charge to the general public for providing the same level of care;
   b. The provider's allowable cost of providing the level of care as described in Section D below; or
   c. The USDR established in Section D.1.b below.

5. The reimbursement methodology for unbundled prescribed physician administered drugs and biologicals used for the treatment of opioid use disorders and alcohol use disorders is the provider's invoice cost or the methodology described in Supplement 2 to Attachment 4.19-B, Page 10.

D. **COST DETERMINATION PROTOCOL FOR COUNTY OPERATED PROVIDERS THAT**

PROVIDE EXPANDED SUBSTANCE USE DISORDER LEVELS OF CARE, NON-COUNTY OPERATED PROVIDERS THAT PROVIDE NON-NTP LEVELS OF CARE, AND ALL PROVIDERS THAT PROVIDE EXPANDED SUBSTANCE USE DISORDER TREATMENT SERVICES REIMBURSED OUTSIDE A LEVEL OF CARE – NON-REGIONAL COUNTIES

The following steps will be taken to determine the reasonable and allowable Medicaid costs for county operated providers that provide Expanded Substance Use Disorder Levels of Care, non-county operated providers that provide non-NTP Levels of Care, and all providers that provide Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care.

1. Interim Payments

Interim payments for all providers that provide non-NTP Levels of Care and Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care to Medi-Cal beneficiaries are made up to the SMA described below. Interim payments for all providers that provide the NTP Level of Care are made up to the USDR described below.

a. SMA METHODOLOGY FOR ALL PROVIDERS OF NON-NTP LEVELS OF CARE AND EXPANDED SUBSTANCE USE DISORDER TREATMENT SERVICES REIMBURSED OUTSIDE A LEVEL OF CARE

SMA rates are established by counties and submitted to the State on an annual basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. SMA rates for Expanded Substance Use Disorder Levels of Care and Expanded Substance Use Disorder Treatment Services Provided Outside a Level of Care are effective as of January 1, 2023 and are published at (please note SMA rates are labeled County Interim Rates):
https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx

b. UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE METHODOLOGY FOR ALL PROVIDERS OF THE NTP LEVEL OF CARE

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is calculated by the State on an annually based on the average daily estimated cost of providing dosing and ingredients, core and laboratory work services as described in Section C. The daily estimated cost does not include room and board and is determined based on the annual estimated cost per patient and a 365-day year, using the most recent and accurate data available. The USDR is paid to county operated and non-county operated NTP providers each day a dose is administered to a beneficiary. NTPs may contract with other entities to perform some work services, such as laboratory work. NTPs pay those outside entities for that work. Those outside entities may not submit claims to the state for reimbursement of work services for which they were paid by the NTP. Outside entities may continue to claim for reimbursement for those services if they are not

provided as part of the NTP Level of Care. The State will periodically monitor the services provided by the NTP for which the USDR was paid to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the USDR.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The USDR rates are effective as of January 1, 2022 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx

The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the median cost, as reported in the most recently submitted cost reports, for individual counseling and group counseling provided in the Outpatient Level of Care as described under Section D.1.a above. The USDR for NTP Individual and Group Counseling are effective as of January 1, 2022 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx

2. Cost Determination Protocol

The reasonable and allowable cost of providing each non-NTP Level of Care, the NTP Level of Care, and Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care will be determined in the CMS-reviewed cost report pursuant to the following methodology. Total allowable costs include direct and indirect costs that are determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75.

Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies, and other costs, such as professional service contracts, that can be directly charged in providing the specific non-NTP Level of Care, NTP Level of Care, or Expanded Substance Use Disorder Treatment Service Reimbursable Outside a Level of Care. Direct practitioners include individuals who are qualified to provide Expanded Substance Use Disorder Treatment Services as defined in Section 13.d.6 of Supplement j3 to Attachment 3.1-A.

In accordance with 2 CFR § 200.416, indirect costs may be determined by either applying the cognizant agency specific approved indirect cost rate to its total direct costs or allocated indirect costs based upon the allocation process in the Legal Entity's approved cost allocation plan. If the Legal Entity does not have a plan, the CMS-reviewed State-developed cost report determines indirect costs as the difference between total costs and direct costs. The CMS-reviewed State-developed cost report allocates indirect costs to each Expanded Substance Use Disorder Level of Care based upon each level of care's

percentage of direct costs.

For the Residential Treatment Level of Care, total allowable costs include direct and indirect costs that are determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75.

Allowable direct costs are costs related to direct practitioners, medical equipment, and medical supplies for providing the service. Direct practitioners include individuals who are qualified to provide Expanded Substance Use Disorder Treatment Services as defined in Section 13.d.6 of Supplement 3 to Attachment 3.1-A.

Indirect costs are determined by applying the cognizant agency approved indirect cost rate to the total direct costs or derived from the provider's approved cost allocation plan. In accordance with 2 CFR §200.416, when there is not an approved indirect cost rate, the provider may allocate those overhead costs that are not directly attributable to the provision of the medical services using a CMS reviewed cost allocation methodology. The CMS-reviewed cost allocation methodology, as implemented in the state-developed cost report, determines indirect costs as the difference between total costs and direct costs. The CMS-reviewed State-developed cost report allocates indirect costs to each Expanded Substance Use Disorder Level of Care based upon each level of care's percentage of direct costs. As stated in Title 2, CFR § 200.56 "indirect costs means those costs incurred for a common or joint purpose benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved." Specifically and in accordance with 2 CFR § 200.416 and 2 CFR part 200, App. VII., ¶ A.1, indirect costs that are directly attributable to the provision of medical services but would generally be incurred at the same level if the medical service did not occur will not be allowable. For those facilities, allowable indirect costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. Costs incurred that "benefit" multiple purpose and would be incurred at the same level if the medical services did not occur are not allowed (e.g., room and board, allocated cost from other related organizations).

The total allowable cost for providing the specific non-NTP Level of Care, NTP Level of Care, or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care by each Legal Entity is further reduced by any third parties' payments received for the services provided in the non-NTP or NTP Level of Care to Medicaid beneficiaries.

The Legal Entity specific unit rate for each non-NTP Level of Care, NTP Level of Care, or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care is calculated by dividing the Medi-Cal allowable cost for

providing the specific non-NTP or NTP Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care by the total number of Units of Service for the Specific non-NTP or NTP Level of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care for the applicable State fiscal year.

3. Apportioning Costs to Medicaid (Medi-Cal)

Total allowable direct and indirect costs allocated to an Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care are apportioned to the Medi-Cal program based upon units of service. For each Expanded Substance use Disorder Level of Care and Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care, the provider reports on the CMS-reviewed State-developed cost report, the total units of service l t provided to all individuals. Units of service are measured in the increments defined in Section C. The total allowable direct and indirect costs allocated to a particular Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care is divided by the total units of service reported for the same level of care or service to determine the cost per units of service.

For each Expanded Substance Use Disorder Level of Care or Expanded Substance Use /Disorder Treatment Service Reimbursed Outside a Level of Care, the provider reports on the CMS-reviewed State-developed cost report the total units of service provided to Medi-Cal beneficiaries. The cost per unit calculated for each level of care or service is multiplied by the total units of that service provided to Medi-Cal beneficiaries to apportion costs to the Medi-Cal program.

The total allowable cost for providing the specific Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care by each Legal Entity is further reduced by any third parties' payments received for the services provided in the non-NTP or NTP Level of Care to Medicaid beneficiaries.

4. Cost Report Submission

Each Legal Entity that receives reimbursement for non-NTP Level of Care, county operated NTP Level of Care, or Expanded Substance Use Disorder Services Reimbursed Outside a Level of Care is required to file a CMS reviewed cost report by November 1 following the end of each State fiscal year. An extension to submit the cost report may be granted by the State.

5. Interim Settlement

The interim settlement will compare interim payments made to each provider

with the total reimbursable costs as determined in the State-developed cost report for the reporting period. Total reimbursable costs are specified under Section B for non-NTP Levels of Care and county operated providers of the NTP Level of Care. If the total reimbursable costs are greater than the total interim payments, the State will pay the provider the difference. If the total interim payments are greater than the total reimbursable costs, the State will recoup the difference and return the Federal share to the Federal government in accordance with 42 CFR § 433.316.

6. Final Settlement Process

The State will perform financial compliance audits to determine data reported in the provider's State developed cost report represents the allowable cost of providing non-NTP or NTP Levels of Care in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75; and the statistical data used to determine the unit of service rate reconcile with the State's record. If the total audited reimbursable cost based on the methodology described under Section B(1) is less than the total interim payment and the interim settlement payments, the State will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR § 433.316. If the total reimbursable cost is greater than the total interim and interim settlement payments, the State will pay the provider the difference.

E. REIMBURSEMENT METHODOLOGY – REGIONAL COUNTIES

1. For county-operated providers, the reimbursement methodology for non-NTP Levels of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care is equal to the allowable costs incurred by the county-operated provider as determined Pursuant to Section F below.

2. For non-county-operated providers, the reimbursement methodology for non-NTP Levels of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care is equal to the prevailing charges for the same or similar non-NTP Level of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care in the county where the provider is located. If prevailing charges are not available, the State will use the best available alternative data, subject to CMS review, that would serve as a reasonable proxy, including the use of trended historical cost data.

3. The reimbursement methodology for the NTP Level of Care provided by non-county operated providers is the lowest of:
    a. The provider's usual and customary charge to the general public for the same or similar level of carae, or
    b. The uniform statewide daily reimbursement rate (USDR) established in Section D.1.b above. The uniform statewide daily reimbursement (USDR)

rates for the daily dosing service, individual counseling and group counseling are calculated by the State on an annual basis. The USDR rates are effective as of January 1, 2022 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx

4. Reimbursement for county-operated providers of the NTP Level of Care is the lowest of:
    a. The provider's usual and customary charge to the general public for providing the same or similar level of care;
    b. The provider's allowable costs of providing the level of care as described in Section F above; or
    c. The USDR established in Section D.1.b above. The uniform statewide daily reimbursement (USDR) rates for the daily dosing service, individual counseling and group counseling are calculated by the State on an annual basis. The USDR rates are effective as of January 1, 2022 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx.

5. The reimbursement methodology for county-operated providers for the payment of prescribed unbundled physician administered drugs and biologicals used for the treatment of opioid use disorders and alcohol use disorders will be reimbursed at the provider's invoice cost or the methodology described in Supplement 2 to Attachment 4.19-B, Page 10.

6. The reimbursement methodology for non-county operated providers for the payment of prescribed unbundled physician administered drugs and biologicals used for the treatment of opioid use disorders and alcohol use disorders will be reimbursed per the methodology described in Supplement 2 to Attachment 4.19-B, Page 10.

F. COST DETERMINATION PROTOCOL FOR EXPANDED SUBSTANCE USE DISORDER TREATMENT LEVELS OF CARE AND EXPANDED SUBSTANCE USE DISORDER TREATMENT SERVICES REIMBURSED OUTSIDE A LEBBEL OF CARE PROVIDED BY COUNTY LEGAL ENTITIES – REGIONAL COUNTIES

The following steps will be taken to determine the reasonable and allowable Medicaid costs for Expanded Substance Use Disorder Treatment Levels of Care and Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care provided by county-operated providers.

1. Interim Payments

Interim payments for all Expanded Substance Use Disorder Treatment Levels of Care and Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care provided to Medi-Cal beneficiaries are reimbursed at the lower of the billed amount or the SMA, per D.1.a, or USDR, per D.1.b, as applicable for services rendered by a county Legal Entity. The Uniform

Statewide Daily Reimbursement (USDR) rates for the daily dosing service, individual counseling, and group counseling are calculated by the State on an annual basis. The USDR rates are effective as of January 1, 2022 and are published at: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-Medi-Cal-Rates.aspx.

2. Cost Determination Protocol – County Legal Entity

The reasonable and allowable cost for a county Legal Entity to provide each Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care will be determined in the State-developed Regional County cost report pursuant to the following methodology. The cost pools include Outpatient Treatment Services, Intensive Outpatient Treatment, Narcotic Treatment Programs, Partial Hospitalization, Residential Treatment, Withdrawal Management, Peer Support Services, Care Coordination Services, MAT for OUD, and MAT for AUD. Total allowable costs include direct and indirect costs that are determined in accordance with the Centers for Medicare and Medicaid Services (CMS Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75.

Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies, and other costs, such as professional service contracts, that can be directly charged to provide the specific Expanded Substance Use Disorder Treatment Level of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care. Direct practitioners include individuals who are qualified to provide Expanded Substance Use Disorder Treatment Services as defined in Section 13.d.6 of Supplement 3 to Attachment 3.1-A.

In accordance with 2 CFR § 200.416, indirect costs may be determined by either applying the cognizant agency specific approved indirect cost rate to its net direct costs, or allocated indirect costs based upon the allocation process in the Legal Entity's approved cost allocation plan. If the Legal Entity does not have a cost allocation plan, the CMS-reviewed State-developed cost report determines indirect costs as the difference between total costs and direct costs. The CMS-reviewed State-developed cost report allocates indirect costs to each Expanded Substance Use Disorder Level of care based upon each level of care's percentage of direct costs.

For the Residential Treatment level of care, allowable costs are determined in accordance with Medicare cost principles, the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75. Allowable direct costs are costs related to direct practitioners, medical equipment, and medical supplies for providing the service. Indirect costs are determined by applying the cognizant

agency approved indirect cost rate to the total direct costs or derived from the provider's approved cost allocation plan. In accordance with 2 CFR § 200.416, when there is not an approved indirect cost rate, the provider may allocate those overhead costs that are directly attributable to the provision of the medical services using a CMS reviewed cost allocation methodology. The CMS-reviewed cost allocation methodology, as implemented in the state-developed cost report, determines indirect costs as the difference between total costs and direct costs. The CMS-reviewed State-developed cost report allocates indirect costs to each Expanded Substance Use Disorder Level of care based upon each level of care's percentage of direct costs. As stated in Title 2, CFR § 200.56 "indirect costs means those costs incurred for a common or joint purpose benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved." Specifically and in accordance with 2 CFR § 200.416 and 2 CFR part 200, App. VII., ¶ A.1. Specifically indirect costs that are directly attributable to the provision of medical services but would generally be incurred at the same level if the medical service did not occur will not be allowable. For those facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. Costs incurred that "benefit" multiple purposes and would be incurred at the same level if the medical services did not occur are not allowed (e.g., room and board, allocated cost from other related organizations.)

The total allowable cost for providing the specific Expanded Substance Use Disorder Treatment Levels of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care by each county Legal Entity is further reduced by any third parties payments received for the Expanded Substance Use Disorder Treatment Level of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care provided. This netted amount I s apportioned to the Medi-Cal program using a basis that must be in compliance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75.

The Legal Entity specific Expanded Substance Use Disorder Treatment Level of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care unit rate is calculated by dividing the Medi-Cal allowable cost for providing the specific Expanded Substance Use Disorder Treatment Level of Care by the total number of UOS, as defined in Section C, for the specific Expanded Substance use Disorder Treatment Level of Care for the applicable State Fiscal Year.

3. Apportioning Costs to Medicaid (Medi-Cal)

Total allowable direct and indirect costs allocated to an Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment

Service Reimbursed Outside a Level of Care are apportioned to the Medi-Cal program based upon units of service. For each Substance Use Disorder Level of Care and Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care, the provider reports on the CMS-reviewed State-developed cost report, the total units of service it provided to all individuals. Units of service are measured in the increments defined in Section C. The total allowable direct and indirect costs allocated to a particular Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care is divided by the total units of service reported for the same level of care or service to determine the cost per unit.

For each Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Service Reimbursed Outside a Level of Care, the provider reports on the CMS-reviewed State-developed cost report the total units of service provided to Medi-Cal beneficiaries. The cost per unit calculated for each level of care or service is multiplied by the total units of that service provided to Medi-Cal beneficiaries to apportion costs to the Medi-Cal program.

The total allowable cost for providing the specific Expanded Substance Use Disorder Level of Care or Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care by each Legal Entity is further reduced by any third parties' payments received for the services provided in the non-NTP or NTP Level of Care to Medicaid beneficiaries.

4. Cost Report Submission

Each Regional County is required to file a State-developed, and CMS-reviewed, cost report by November 1 following the close of the State fiscal year.

5. Interim Settlement

The interim settlement will compare interim payments made to each county operated provider with the total reimbursable costs as determined in the Regional County State-developed cost report for the reporting period. Total reimbursable costs for county-operated Legal Entities are specified under Section F.2 for all Expanded Substance Use Disorder Treatment Levels of Care and Expanded Substance Use Disorder Treatment Services Reimbursed Outside a Level of Care.

If the total reimbursable costs are greater than the total interim payments, the State will pay the county operated provider the difference. If the total interim payments are greater than the total reimbursable costs, the State will recoup the difference and return the Federal share to the Federal government in accordance with 42 CFR § 433.316.

6. Final Settlement Process

The State will perform a financial compliance audit to determine if the data reported in the Regional County State-developed cost report represent the allowable cost of providing Expanded Substance Uses Disorder Treatment Levels of Care in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub 15-1), CMS non-institutional reimbursement policies, 45 CFR § 75.302, 42 CFR § 447.202, and 2 CFR part 200 as implemented by HHS at 45 CFR part 75, and the statistical data used to determine the unit of service rate reconciled with State's records. If the total audited reimbursable cost is less than the total interim payment and the interim settlement payments, the State will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR § 433.316. If the total reimbursable cost is greater than the total interim and interim settlement payments, the State will pay the provider the difference.

G. REGIONAL COUNTIES

Humboldt
Lassen
Mendocino
Modoc
Shasta
Siskiyou
Solano

H. NON REGIONAL COUNTIES

Alameda	Napa	San Joaquin
Contra Costa	Nevada	San Luis Obispo
El Dorado	Orange	San Mateo
Fresno	Placer	Santa Barbara
Imperial	Riverside	Santa Clara
Kern	Sacramento	Santa Cruz
Los Angeles	San Benito	Stanislaus
Marin	San Bernardino	Tulare
Merced	San Diego	San Francisco
Monterey	San Francisco	Yolo

REIMBURSEMENT FOR 1905(a)(29) MEDICATION ASSISTED TREATMENT FOR OPIOID USE DISORDERS

1. Payment for a) unbundled and bundled services; and b) bundled services and prescribed drugs and biologicals administered by a provider for the treatment of opioid use disorders are reimbursed per the Drug Medi-Cal Program methodologies described in Attachment 4.19-B, starting on page 38.

2. Payment for unbundled prescribed drugs and biologicals used for the treatment of opioid use disorders are reimbursed per the methodology described in Supplement 2 to Attachment 4.19-B, Pages 1-10 for drugs that are dispensed or administered.

3. For Regional Counties and Non-Regional Counties, payment for unbundled prescribed physician administered drugs and biologicals used for the treatment of opioid use disorders are reimbursed per the methodology described in Attachment 4.19-B, Page 41i, 41j, 41o, and 41p.